VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

February 21, 2023

Ms. Amy Walker, Administrator
Burlington Health & Rehab
300 Pearl Street
Burlington, VT 05401-8531

Dear Ms. Walker:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 19, 2023.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M Cota RN

Pamela M. Cota, RN
Licensing Chief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475014	A. BUILDING _____ B. WING _____	C 01/19/2023

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BURLINGTON HEALTH & REHAB	300 PEARL STREET BURLINGTON, VT 05401

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F 000	INITIAL COMMENTS An unannounced onsite investigation of complaint #21382 and #21429 was completed by the Division of Licensing and Protection on 1/4/2023 through 1/10/2023. On 1/10/2023, the survey team identified and notified the facility of deficiencies at the immediate jeopardy (IJ) level for F684, F686, and F726 related to violations around skin care and staff training. This IJ determination also results in substandard quality of care. The facility is licensed for 126 beds and had a census of 87 at the time of the survey. Prior to exit on 1/10/23, the facility had completed sufficient corrective actions to remove the immediate jeopardy, but the non-compliance with requirements remains. An extended survey was conducted from 1/17/2023 through 1/19/2023 due to the substandard quality of care identified on 1/10/2023. The following regulatory violations were identified:	F 000		
F 684 SS=K	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide care to an existing non-pressure related injury for 2 of 2 sampled residents [Residents #2 and #8] and preventative skin care	F 684		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

[signature], Administrator — 2/11/2023

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F 684	Continued From page 1 to residents at risk for development of non-pressure related injuries for 5 of 6 sampled residents [Residents #1, #2, #3, #6, and #8] consistent with facility policy and professional standards of practice. Findings include: Record review and interview reveal the facility had multiple systemic failures in its prevention and management of non-pressure injuries in accordance with facility policy and professional standard of practice. These included failure to: Complete an accurate comprehensive skin evaluation on admission for Residents #1 and #2; Complete skin risk evaluations per facility schedule for Residents #1, #2, #3, #6, and #8; Document newly identified non-pressure ulcer skin impairments as a change of condition for Resident #2; Accurately and regularly perform and document skin inspections (skin checks) per facility schedule for Residents #1, #3, #6, and #8; Accurately and regularly perform non-pressure ulcer wound evaluations per facility schedule for Residents #2 and #8; Perform and document daily monitoring of non-pressure ulcer wounds or dressings for Resident #8; Revise care plans to reflect actual skin status for Resident #2; Create care plans to monitor diabetic residents' feet for Residents #1, #3, and #8; and Monitor diabetic residents' feet for Residents #1, #2, and #3. These failures contributed to the amputation of Resident #2's 5th toe, and put Residents #1, #2, #3, #6, and #8 at increased risk for new or	F 684	This plan of correction (POC) was written to follow state and federal guidelines. It is not an admission of noncompliance. However, it is the facility commitment to demonstrate and maintain compliance. F 684 Specific Corrective Action Resident # 2 was discharged on 1.30.2023 Resident # 8 orders for wound care to BLE were reviewed and are affirmed in place per order. The resident's care plan has been updated. Resident's # 1,3, 6 and 8 were evaluated, preventative skin care is in place as per each resident's updated care plan. Licensed nursing staff was educated on change in condition, skin integrity and wound management, wound care dressing guidelines, and documentation of skin care provided. LNA staff was educated on pressure relieving devices, nutrition/hydration, repositioning, change in condition, shower schedule, Diabetic and foot care, and preventive skin care.	03/03/23

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F 684	Continued From page 2 additional non-pressure ulcer related skin impairments, creating an immediate jeopardy situation for serious injury to recur if immediate corrective action was not taken. Facility policy titled NSG236 Skin Integrity and Wound Management, last reviewed 9/1/22, states: "A comprehensive initial and ongoing nursing assessment of intrinsic and extrinsic factors that influences skin health, skin/wound impairment, and the ability of a wound to heal will be performed. The plan of care for the patient will be reflective of assessment findings from the comprehensive patient assessment and wound evaluation. Staff will continually observe and monitor patients for changes and implement revisions to the plan of care as needed." Practice Standards include: "3. Complete risk evaluation on admission, re-admission, weekly for the first month, quarterly, and with significant change in condition." "5. The nursing assistant will observe skin daily and report any changes or concern to the nurse." "6. A licensed nurse will: 6.1 Evaluate any reported or suspected skin changes or wounds 6.2 Document newly identified skin/wound impairments as a change in condition 6.4 Perform and document skin inspection on all newly admitted/readmitted patients weekly thereafter and with any significant change of condition 6.5 Complete wound evaluation upon admission/readmission, new in-house acquired, weekly, and with unanticipated decline in wounds. 6.6 Perform daily monitoring of wounds or dressings for presence of complications or	F 684	. F684 cont Method to Assess for Others A facility wide skin sweep was performed and completed by 01/10/23 by DON/designee to evaluate each resident's skin status to determine if any follow-up care and services were indicated. This is continued by weekly individualized resident head to toe skin observations. A resident record audit was also performed to evaluate compliance with preventative skin care, head to toe skin assessment, shower schedule, treatment, notification of change. Systematic Process An ad hoc QAA was performed to complete a systematic review with revisions as determined/ indicated. New LNAs will be oriented and annually educated on pressure relieving devices, nutrition/hydration, repositioning, change in condition, shower schedule, Diabetic and foot care, and preventive skin care.	

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F 684	Continued From page 3 declines. 6.6.1 Document daily monitoring of ulcer/wound site with or without dressing." "8. Review care plan and revise as indicated." Facility policy titled Wound Dressing: Aseptic No Touch, last reviewed 12/1/2021, states staff are to verify the wound dressing order before changing dressings and document wound evaluation with unanticipated wound decline and/or weekly if assessment is due. The American Diabetes Association "Standards of Care in Diabetes-2023" reveals on page S209 the recommendation for diabetics to perform daily examination of the feet to identify early foot problems. 1. Resident #2 Record review and interview reveal that a diabetic foot ulcer was discovered on Resident #2's left foot on 12/9/22. The facility failed to provide accurate and regular skin and wound assessments, initiate a change of condition in the electronic medical record (EMR), implement care plan interventions for daily diabetic foot monitoring, and revise his/her care plan to reflect his/her clinical condition and needs placing him/her at increased risk for wound complications and other non-pressure ulcer skin impairments. The deterioration of Resident #2's diabetic ulcer resulted in an amputation of his/her 5th toe on 1/4/23. Record Review: Resident #2 was initially admitted to the facility on 7/29/22 and readmitted to the facility from the hospital on 9/1/22 with diagnoses that include type 2 diabetes mellitus, chronic respiratory	F 684	F684 cont. Licensed nurses will be oriented and annually educated on change in condition, skin integrity and wound management, wound care dressing guidelines, and documentation of skin care provided. A risk evaluation is now completed on admission, re-admission, weekly for the first month of stay, quarterly and with any possible significant change. Each facility resident now has a formalized schedule head to toe skin checks weekly, bi-weekly bathing, foot observations during care and during specific individualized ankle to toe foot care as noted on order sets and documented on the treatment administrative records, LNA documentation and resident individualized care plan for individualized preventative care. In the event of change of condition or status and or non-pressure related observations, the resident's practitioner will be alerted for guidance and orders, resident and or responsible party will be notified with the care plan individually updated. The Unit Manager/designee will do	

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F 684	Continued From page 4 failure, hypertension, chronic pain syndrome, chronic kidney disease, arthritis, anemia, congestive heart failure, legal blindness, and depression. Resident #2's care plan dated 8/9/22 reveals s/he needs staff assistance for transferring and toileting. These clinical conditions and comorbidities are risk factors for developing skin injuries. A 9/1/22 transition of care note [discharge summary] from the hospital reveals on pages 5-8 that Resident #2 had multiple assessed wounds and dressings including: a right heel wound described as red, with a small open area and boggy with a foam dressing; a left heel wound described as red and boggy with a foam dressing; and a left planter foot wound, described as black, brown, and open to air. Upon return to the facility, the 9/1/22 nursing skin assessment does not document the above wounds noted in the 9/1/22 transition of care. Resident #2's care plan includes the following care plan focuses: "Resident is at risk of skin breakdown r/t [related to] Seborrheic Dermatitis [skin condition affecting the scalp] < DM [diabetes] and alterations in mobility," created on 8/9/22. Interventions include: "Observe skin for signs/symptoms of skin breakdown i.e. redness, cracking, blistering, decrease sensation, and skin that does not blanche easily," created on 8/9/22, and "Weekly skin check by license nurse," created on 8/9/22. "The resident has a diagnosis of diabetes: Insulin Dependent," created on 8/3/22. Interventions include: "Diabetic foot checks daily. Observe feet/toes/ankles/soles/heels noting alteration in skin integrity, color, temperature, and	F 684	F684 cont daily review of the electronic health record (EHR) to evaluate documentation of the completion of scheduled skin care, weekly head to toe skin checks, shower schedule and wound care. The Unit Manager/designee will make weekly skin care resident skin care rounds. The Unit Manager/designee will make daily visual rounds to visualize care on all three shifts to evaluate staff completion and competency as well as individual resident skin status. Quality Assurance The Director of Nursing (DON) will be responsible for ensuring that this system is in place. The DON will also complete a weekly audit of eight residents per month to evaluate their skin status, confirmation that anything present has been appropriately identified by the system and that the system was followed through detection, notification of change, care and documentation.	

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F 684	Continued From page 5 cleanliness," created on 8/3/22. A Nurse Practitioner (NP) note dated 12/9/22 reveals in a physical exam that Resident #2 has a "L [left] planter 5th mtp [Metatarsophalangeal; where the bones of the toe and foot meet] diabetic ulcer pale white lifting of dermis [middle layer of skin] beefy protrusion dime size." The provider notes "There is this open area dorsal 5th mtp that no one was aware of. Severe neuropathy." The treatment plan indicates a referral to the wound nurse. The NP also notes a "non-pressure chronic ulcer of other part of right foot with fat layer exposed." A skin check dated 12/9/22 reveals a new skin wound described as a ".5 x .5 hard, blanchable, white area to bottom of left foot." There is no mention of a non-pressure chronic ulcer of the right foot as indicated in the NP's note from an hour earlier. Resident #2's care plan was updated on 12/10/22 to include "Blanchable areas to heels." The care plan does not acknowledge Resident #2's left foot wound. No interventions were added to the care plan for wound care or wound evaluations. A Wound Nurse note dated 12/28/22 reveals an initial evaluation of Resident #2's diabetic foot wound measuring 1.1 x 1.1 x 4.3 cm. A 12/30/22 nursing home to hospital transfer form reveals that Resident #2 was transferred to the hospital on 12/30/22 due to pain in his/her left lateral foot. Review of Resident #2's medical record reveals that s/he does not have:	F 684	F684 cont.. Any concerns identified will be addressed at the time of recognition. Results of the DON audit and process will be included in the facility monthly risk management/quality improvement meeting for additional consideration as determined appropriate. **Tag F 684 POC accepted on 2/16/23 by S. Stem/P. Cota**	

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F 684	Continued From page 6 An accurate comprehensive readmission skin evaluation on 9/1/22; A Braden Scale risk assessment [score predicting the risk of developing pressure sores] from 8/8/22 through 12/20/22; A change of condition documentation for the wound identified on 12/9/22; Weekly wound evaluations from 12/10/22 through 12/28/22; Documentation of daily diabetic foot checks from 9/1/22 through 12/30/22; or A care plan focus that reflects actual wounds. The facility was unable to produce evidence of missing risk assessments, change of condition documentation, wound evaluations, or documentation of diabetic foot checks for Resident #2 when requested on 1/10/23 at 10:20 AM by the surveyor. A 1/9/23 hospital progress note reveals that Resident #2 was admitted to the hospital on 12/30/22 for a left planter foot ulcer with osteomyelitis [bone infection] and MRSA [Methicillin-resistant Staphylococcus aureus; bacterial infection]. As a result, Resident #2 had a left 5th partial ray resection [amputation of 5th toe] on 1/4/23. Interview: On 1/5/23 at 2:48 PM the Medical Director confirmed that nursing orders for daily foot checks for diabetic residents is a standard of care and should be a standard nursing order for all diabetic residents. On 1/6/22 at 11:55 AM, the Director of Nursing confirmed that the facility policy titled Skin	F 684		

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F 684	Continued From page 7 Integrity and Wound Management should be followed by nursing staff for all residents. On 1/6/22 at 12:30 PM, the Regional Clinical Consultant stated that it is up to nursing judgment to add diabetic foot checks into nursing orders or care plans as it is not something standard the facility does for all diabetics. S/He confirmed that there is not written policy or procedure in place to ensure that a residents transfer of care information for wounds is entered into [the electronic medical record system]. On 1/9/23 at 9:20 AM, the Unit Manager stated that there is a diabetic protocol that should be implemented for every resident with diabetes and once triggered, it will add orders for daily diabetic foot checks. S/He stated that a lot of the nurses are "working to the order" [only doing what there is an order for] and might not do daily diabetic foot checks if there is not an order on a resident's MAR. S/He stated that there is not a facility procedure on how to enter in orders and staff need something to refer to about the process. On 1/9/23 at 12:15 AM, a Licensed Practical Nurse (LPN) stated that s/he will do daily diabetic foot checks when they pop up on the medication administration record (MAR) or treatment administration record (TAR). On 1/9/23 at 1:22 PM, the Director of Nursing stated that when a change of condition form is filled out for new wounds, weekly skin and wound evaluations will auto populate in the EMR. S/He confirmed that a change of condition form is not being done all the time per facility policy and it might be due to a training issue.	F 684		

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On 1/9/23 at 3:19 PM, an LPN stated that s/he will do a diabetic foot check when there is an order on the TAR to do one.

On 10/10/23 at 10:20 AM, the Director of Nursing confirmed that the skin risk evaluation used by the facility was the "Braden Scale for Predicting Pressure Sore Risk Assessment."

On 1/10/23 at 11:55 AM, the Wound Nurse stated that if a provider plans for a resident to see the wound nurse, the referral should happen immediately. S/He confirmed that s/he did not get a referral to see Resident #2 until the end of December.

On 1/18/23 at 9:40 AM, the Director of Nursing and the Market President confirmed that the failures to implement the skin and wound policies and procedures were due to a mix of staff not having the enough training on the policies and procedures and staff not having the competencies to implement them.

2. Resident #8

Record review and interview reveal that Resident #8 has venous ulcers on both legs since his/her initial admission. The facility failed to provide accurate and regular skin and wound assessments and create a care plan intervention for daily diabetic foot monitoring, placing Resident #8 at increased risk for wound complications and other non-pressure ulcer skin impairments.

Record Review:

Resident #8 was admitted to the facility on 11/27/20 with diagnoses that include type 2

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diabetes mellitus, hypertension, peripheral vascular disease, chronic kidney disease, obesity, and coronary artery disease. Resident #8's Minimum Data Set (MDS; a comprehensive assessment used as a care-planning tool) dated 11/14/22 reveals that s/he is at risk for developing pressure ulcers and needs staff assistance for transferring and toileting. These clinical conditions and comorbidities are risk factors for developing skin injuries.

Resident #8's care plan includes the following care plan focus:
"[Resident #8] is at risk for skin break down related to osteoarthritis, PVD [peripheral vascular disease], bilateral mastectomy. Resident currently has venous ulcers to right and left posterior legs and abrasion to left calf," created on 11/27/20. Interventions include: "Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx [signs and symptoms] of infection, maceration [moist skin] etc. to MD," created on 11/27/20, and "skin/wounds will be checked weekly by licensed professional," created on 10/18/22. The care plan does not include daily diabetic foot checks.

Resident #8's medication administration record (MAR) reveals an order to "Cleanse BLE [bilateral lower extremities] with wound cleaner. Pat dry. Apply moisturizing cream to intact skin. For RLE [right lower extremity] only iodosorb cream. Apply iodine cadexomer gel to open areas and cover with foam [cover with Ag/silver foam if iodine not available]. Wrap with roller gauze (kerlix) and adhesive wrap (Coban) every evening shift, every 2 day(s) for venous ulcers." This order was documented as completed throughout October.

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Skin checks from 10/1/22 and 10/11/22 indicate that Resident #8 does not have any skin injuries or wounds. This information contradicts the dressing changes for wounds documented as performed in the MAR.

Review of Resident #8's medical record reveals that s/he does not have:
A Braden Scale risk assessment from 2/12/21 through 1/11/23;
Weekly skin checks from 8/28/22 through 9/30/22;
Accurate skin checks from 10/1/22 through 10/17/22;
Weekly skin checks from 12/13/22 through 1/5/23;
Documentation of daily monitoring for wound/dressing on days that Resident #8's dressing was not changed;
Weekly wound evaluations from 9/9/22 through 9/28/22;
A weekly wound evaluation from 10/7/22 through 10/19/22; or
A care plan intervention for daily diabetic foot checks from 11/27/20 through 1/5/23.

Interview:

On 1/9/23 at 4:03 PM, the Regional Clinical Consultant stated that there is an expectation for staff to document any irregularities of the skin, not just wounds, whether they are new or not. S/he confirmed that skin checks are a full body assessment of a resident's skin.

On 1/18/23 at 9:15 AM, the Unit Manager stated that traveling nursing staff do not get enough education when they are hired and that some staff do not document wounds on skin checks if

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the wound is not new. S/He confirmed that Resident #3 had venous ulcers on both legs during October 2022 and if skin checks stated that Resident #3 did not have any wounds on 10/1/22 or 10/11/22, the skin checks would not be accurate.

On 1/18/23 at 11:00 AM, the Director of Nursing confirmed that there is no evidence that skin checks or wound evaluations were completed for the above dates per facility policy and Resident #8's care plan.

3. Resident #1

Record review and interview reveal that the facility failed to provide timely and regular skin and wound assessments, initiate a change of condition in the electronic medical record, and create and implement care plan interventions for daily diabetic foot monitoring, placing Resident #1 at increased risk for non-pressure ulcer skin impairments.

Record Review:

Resident #1 was readmitted to the facility on 9/14/22 following a hospital stay with diagnoses that included: type 2 diabetes mellitus, altered cardiac status, obesity, frequent incontinence, renal insufficiency, chronic obstructive pulmonary disease, chronic respiratory failure, severe chronic kidney disease, congestive heart failure, atrial fibrillation, amputation of the right toe, anemia, osteoporosis, hypertension, rheumatoid arthritis, muscle weakness, chronic pain, and history of urinary tract infections, seizures, and stroke. Resident #1's MDS dated 9/14/22 reveals that s/he requires two-person assist for bed

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mobility, toileting, and transfers. These clinical conditions and comorbidities are risk factors for developing skin injuries.

Resident #1's care plan includes the following care plan focus:
"Resident is at risk of skin breakdown r/t [related to] DM [diabetes], incontinence (B&B) [bowel and bladder]. Has redness to grain and abdominal folds. Has absence of right toes" created on 2/16/22. Interventions include "assess for changed in skin condition each shift," created on 2/16/22, and "complete skin risk assessment as per facility policy," created on 2/16/22. The care plan does not include daily diabetic foot checks.

Review of Resident #1's medical record reveals that s/he does not have:
A Braden Scale risk assessment from 3/13/22 through 1/3/23;
A comprehensive skin assessment on 9/14/22 readmission;
Weekly skin checks from 9/14/22 through 9/26/22;
Weekly skin checks from 11/25/22 through 12/13/22;
A care plan intervention for daily diabetic foot checks from 9/14/22 through 10/14/22; or
Documentation of daily diabetic foot checks from 9/14/22 through 12/13/22.

The facility was unable to produce evidence of missing risk assessments, change of condition documentation, wound evaluations, or documentation of diabetic foot checks for Resident #1 when requested on 1/10/23 at 10:20 AM by the surveyor.

Interview:

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F 684	Continued From page 13 On 1/4/23 at 2:55 PM, the Unit Manager stated that there is a glitch with putting in orders for readmissions. When a resident is out of the facility for three or more days, orders are deleted, and the nurse must start from scratch to put orders in. There is no way of knowing what the previous orders were for a readmission but standard nursing orders, like skin assessments, should be in the electronic medical record system. On 1/5/23 at 2:48 PM the Medical Director confirmed that head to toe skin checks are to be done for all residents on return from the hospital. On 1/6/23 at 10:52 AM, the Administrator confirmed that there was no evidence of a readmission skin assessment on 9/14/22. On 1/10/23 at 9:50 AM, an LPN stated that skin checks and diabetic foot checks will pop up on the TAR if they are due. When asked if the diabetic residents on his assignment that day need their feet checked every day, s/he stated he was unaware that they did. On 1/10/23 at 4:10 PM, Resident #1 stated that staff did not look at his/her feet every day. 4. Resident #3 Record review and interview reveal that the facility failed to provide regular skin assessments and create and implement care plan interventions for daily diabetic foot monitoring, placing Resident #3 at increased risk for non-pressure ulcer skin impairments.	F 684		

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F 684	Continued From page 14 Record Review: Resident #3 was admitted to the facility on 12/20/22 with diagnoses that include type 2 diabetes mellitus, hypertension, left foot drop, muscle weakness, dementia, depression, and history of stroke. Resident #3's MDS dated 12/26/22 reveals that s/he is at risk for developing pressure ulcers and totally dependent on staff, requiring a two person assist for bed mobility, transferring, and toileting. These clinical conditions and comorbidities are risk factors for developing skin injuries. Resident #3's care plan includes the following care plan focus: "Patient is at risk for skin breakdown related to Advanced age (greater than 75 years), decreased activity, impaired Cognition, incontinence, limited mobility, nutritional concerns and or has actual skin integrity impairments-admitted with bruises to abdomen and bilateral arms," created on 12/21/22. Interventions include: "Weekly skin check by license nurse" created on 12/21/22. The care plan does not include daily diabetic foot checks. Review of Resident #3's medical record reveals that s/he does not have: A Braden Scale risk assessment from 12/20/22 through 1/8/23; A weekly skin check from 12/21/22 through 1/5/23; A care plan intervention for daily diabetic foot checks from 12/20/22 through 1/5/23; or Documentation of daily diabetic foot checks from 12/20/22 through 1/5/23. The facility was unable to produce evidence of	F 684		

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missing risk assessments, skin checks, or documentation of diabetic foot checks for Resident # 3 when requested on 1/10/23 at 10:20 AM by the surveyor.

5. Resident #6

Record review and interview reveal that the facility failed to provide timely and regular skin and wound assessments placing Resident #6 at increased risk for non-pressure ulcer skin impairments.

Record Review:

Resident #6 was admitted to the facility on 6/22/05 with diagnoses that include multiple sclerosis, muscle weakness, and dementia. Resident #3's MDS dated 11/30/22 reveals that s/he is at risk for developing pressure ulcers and needs extensive or full assistance, requiring a two person assist for bed mobility, transferring, and toileting. These clinical conditions and comorbidities are risk factors for developing skin injuries.

Resident #6's care plan includes the following care plan focuses:
"Resident at risk for skin breakdown related to impaired mobility, advanced age, poor safety awareness, frail/fragile skin, incontinence," created on 8/18/22. Interventions include:
"Weekly skin check by license nurse," created on 8/18/22 and "Observe skin for signs/symptoms of skin breakdown i.e. redness, cracking, blistering, decrease sensation, and skin that does not blanche easily," created 8/18/22.
"The resident has potential for pressure ulcer development r/t [related to] decreased mobility,"

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F 684	Continued From page 16 created on 2/15/21. Interventions include: "Follow facility protocols for the prevention/treatment of skin breakdown," created on 2/15/21 and, "Document/report to MD PRN [as needed] changes in skin status: appearance, color, wound healing, s/sx [signs and symptoms] of infection, wound size and stage," created on 2/15/21. A physician's order dated 7/27/22 states to "Check skin condition to bilateral lower extremities daily every shift for fragile skin document in nurses note any new skin concerns". Review of Resident #6's medical record reveals that s/he does not have: A Braden Scale risk assessment from 2/26/22 through 1/11/23; or Weekly skin checks from 11/24/22 through 1/5/23. Interview: On 1/17/23 at 11:03 AM, the Director of Nursing confirmed there is no evidence that skin checks were done as care planned and ordered in December 2022.	F 684		
F 686 SS=K	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and	F 686		

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F 686	Continued From page 17 (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide treatment to an existing pressure injury for 2 of 2 sampled residents [Residents #1 and #6] and preventative skin care to residents at risk for development of pressure injuries for 5 of 6 sampled residents [Residents #1, #2, #3, #6, and #8] consistent with facility policy and professional standards of practice. Findings include: Record review and interview reveal the facility had multiple systemic failures in its prevention and management of pressure injuries in accordance with facility policy and professional standard of practice. These included failure to: Complete an accurate comprehensive skin evaluation on admission for Residents #1 and #2; Complete skin risk evaluations per facility schedule for Residents #1, #2, #3, #6, and #8; Document newly identified pressure injuries as a change of condition for Resident #1; Accurately and regularly perform and document skin inspections (skin checks) per facility schedule for Residents #1, #3, #6, and #8; Accurately and regularly perform wound evaluations for pressure injuries per facility schedule for Resident #1; Provide pressure ulcer dressing changes or treatment for Resident #1; Perform and document daily monitoring of pressure injuries or dressings for Resident #1;	F 686	Resident # 1 was evaluated and is free from pressure injuries. Resident # 6 was evaluated. Pressure injury orders are in place and being followed. Resident # 2 was discharged on 1.30.2023. Resident's # 1,3, 6 and 8 were evaluated, preventative skin care is in place as per each resident's updated care plan. Licensed nursing staff was educated on change in condition, skin integrity and wound management, wound care dressing guidelines, and documentation of skin care provided. LNA staff was educated on pressure relieving devices, nutrition/hydration, repositioning, change in condition, shower schedule, Diabetic and foot care, and preventive skin care.	03/03/23

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F 686	Continued From page 18 Revise care plans to reflect actual skin status for Resident #1; Create care plans to monitor diabetic residents' feet for Residents #1, #3, and #8; and Monitor diabetic residents' feet for Residents #1, #2, and #3. These failures contributed to a below the knee amputation for Resident #1, a delay in pressure ulcer treatment for Resident #6, and put Residents #1, #2, #3, #6, and #8 at risk for developing new or additional pressure ulcers, creating an immediate jeopardy situation for serious injury to recur if immediate corrective action was not taken. Facility policy titled NSG236 Skin Integrity and Wound Management, last reviewed 9/1/22, states: "A comprehensive initial and ongoing nursing assessment of intrinsic and extrinsic factors that influences skin health, skin/wound impairment, and the ability of a wound to heal will be performed. The plan of care for the patient will be reflective of assessment findings from the comprehensive patient assessment and wound evaluation. Staff will continually observe and monitor patients for changes and implement revisions to the plan of care as needed." Practice Standards include: "3. Complete risk evaluation on admission, re-admission, weekly for the first month, quarterly, and with significant change in condition." "5. The nursing assistant will observe skin daily and report any changes or concern to the nurse." "6. A licensed nurse will: 6.1 Evaluate any reported or suspected skin changes or wounds 6.2 Document newly identified skin/wound	F 686	F686 cont... Method to Assess for Others A facility wide skin sweep was performed and completed by 01/10/23 by DON/designee to evaluate each resident's skin status to determine if any follow-up care and services were indicated. This is continued with weekly head to toe skin evaluations. A resident record audit was also performed to evaluate compliance with preventative skin care, head to toe skin assessment, shower schedule, treatment, notification of change. Systematic Process An ad hoc QAA was performed to complete a systematic review with revisions as indicated. New LNAs will be oriented and annually educated on pressure relieving devices, nutrition/hydration, repositioning, change in condition, shower schedule, Diabetic and foot care, and preventive skin care.	

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F 686	Continued From page 19 impairments as a change in condition 6.4 Perform and document skin inspection on all newly admitted/readmitted patients weekly thereafter and with any significant change of condition 6.5 Complete wound evaluation upon admission/readmission, new in-house acquired, weekly, and with unanticipated decline in wounds. 6.6 Perform daily monitoring of wounds or dressings for presence of complications or declines. 6.6.1 Document daily monitoring of ulcer/wound site with or without dressing." "8. Review care plan and revise as indicated." Facility policy titled Wound Dressing: Aseptic No Touch, last reviewed 12/1/2021, states staff are to verify the wound dressing order before changing dressings and document wound evaluation with unanticipated wound decline and/or weekly if assessment is due. The American Diabetes Association "Standards of Care in Diabetes-2023" reveals on page S209 the recommendation for diabetics to perform daily examination of the feet to identify early foot problems. 1. Resident #1 Record review and interview reveal that Resident #1 was readmitted to the facility from the hospital on 9/14/22 with a deep tissue pressure injury. The facility failed to provide timely and regular skin and wound assessments, provide pressure ulcer treatment and dressing changes, initiate a change of condition in the electronic medical record, revise his/her care plan to reflect his/her clinical condition and needs, and create and implement care plan interventions for daily	F 686	Licensed nurses will be oriented and annually educated on change in condition, skin integrity and wound management, wound care dressing guidelines, and documentation of skin care provided. A risk evaluation is now completed on admission, re-admission, weekly for the first month of stay, quarterly and with any possible significant change. Each facility resident now has a formalized schedule head to toe skin checks weekly, bi-weekly bathing, foot observations during care and during specific individualized ankle to toe foot care as noted on order sets and documented on the treatment administrative records,	

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F 686	Continued From page 20 diabetic foot monitoring, placing Resident #1 at increased risk for wound complications and developing additional pressure ulcers. The deep tissue injury progressed to an unstageable pressure wound by 9/29/22, fifteen days after readmission to the facility. Once the wound was documented as discovered, the facility continued to fail to implement skin integrity and wound management interventions. The deterioration of Resident #1's pressure injury resulted in a below the knee left leg amputation on 12/20/22. Record Review: Resident #1 was initially admitted to the facility on 2/11/22. Since then, Resident #1 has had extended hospital stays of three or more days on 6/6/22-6/21/22, 6/22/22-6/30/22, 7/1/22-8/1/22, 8/14/22-8/25/22, 9/5/22-9/14/22, and 12/13/22-1/4/23. Resident #1 was readmitted to the facility on 9/14/22 following a hospital stay with diagnoses that included: type 2 diabetes mellitus, altered cardiac status, obesity, frequent incontinence, renal insufficiency, chronic obstructive pulmonary disease, chronic respiratory failure, severe chronic kidney disease, congestive heart failure, atrial fibrillation, amputation of the right toe, anemia, osteoporosis, hypertension, rheumatoid arthritis, muscle weakness, chronic pain, and history of urinary tract infections, seizures, and stroke. Resident #1's Minimum Data Set (MDS; a comprehensive assessment used as a care-planning tool) dated 9/14/22 reveals that s/he requires two-person assist for bed mobility, toileting, and transfers. These clinical conditions and comorbidities are risk factors for developing pressure ulcers.	F 686	F686 cont... LNA documentation and resident individualized care plan for individualized preventative care. In the event of change of condition or status and or non-pressure related observations, the resident's practitioner will be alerted for guidance and orders, resident and or responsible party will be notified with the care plan individually updated. The Unit Manager/designee will do daily review of the electronic health record (EHR) to evaluate documentation of the completion of scheduled skin care, weekly head to toe skin checks, shower schedule and wound care. The Unit Manager/designee will make weekly skin care resident skin care rounds. The Unit Manager/designee will make daily visual rounds to visualize care on all three shifts to evaluate staff completion and competency as well as individual resident skin status.	

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F 686	Continued From page 21 The transition of care (discharge summary) from the hospital on 9/14/22 reveals on page 3 that Resident #1 needed follow up with the podiatry clinic for a left heel ulcer. Page 6 indicates that Resident #1 had a left heel deep tissue pressure injury. It is documented on page 7 that on 9/14/22 at 9:30 am, the heel wound had a clean, dry, and intact foam dressing. There is no evidence that the facility completed a skin risk evaluation, skin inspection, wound evaluation, or monitoring of wound and/or dressing when Resident #1 was readmitted on 9/14/22's. Resident #1's care plan on 9/14/22 includes the following care plan focus: "Resident is at risk of skin breakdown r/t [related to] DM [diabetes], incontinence (B&B) [bowel and bladder]. Has redness to groin and abdominal folds. Has absence of right toes" initiated on 2/16/22. Interventions include "assess for changed in skin condition each shift," initiated 2/16/22, and "complete skin risk assessment as per facility policy," initiated 2/16/22. The care plan does not address his/her deep tissue injury or include interventions to care for the wound present on 9/14/22. Also, the care plan does not include daily diabetic foot checks or reflect Resident #1's actual wound. A progress note signed and dated on 9/27/22 2:47 PM, thirteen days after readmission by the Unit Manager, reveals "Evaluated left heel area found wrapped with kling [gauze bandage] covered with foam dressing noted to have circular necrotic center with yellow slough surrounding edges. Foul odor noted. Notified [physician]. awaiting return call. Foam dressing applied with	F 686	Quality Assurance The DON will be responsible for ensuring that this system is in place to support adherence to the pressure injury program. F686 cont... The DON will complete a weekly audit of eight residents per month to evaluate their skin status, confirmation that anything present has been appropriately identified by the system and that the system was followed through detection, notification of change, care and documentation. Any concerns identified will be addressed at the time of recognition. Results of the DON audit and process will be included in the facility monthly risk management/quality improvement meeting for additional consideration as determined appropriate. **Tag F 686 POC accepted on 2/16/23 by S. Stem/P. Cota**	

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F 686	Continued From page 22 kling. Will place resident on list for wound nurse on Thursday." Review of Resident #1's medication administration record (MAR), treatment administration record (TAR), Licensed Nurse Aide (LNA) documentation, physician's orders, progress notes, provider notes, and assessment tools does not reveal any of the following for Resident #1 between the time s/he was readmitted on 9/14/22 and the time the wound was first documented on 9/27/22: a comprehensive skin assessment, skin risk assessments, skin checks, nursing assistants reporting skin concerns to the nurse, wound evaluations, a change in condition form, orders for dressing changes or treatments, daily diabetic foot checks, or daily monitoring of wounds and/or dressings. A Wound Nurse note dated 9/29/22 documented the visit as the initial encounter and recorded that Resident #1's pressure ulcer appears infected. A Nurse Practitioner note dated 9/30/22 indicated that Resident #1's wound was approximately 3x2 inches in size and is described as eschar [dark, crusty tissue]. A Wound Nurse progress note from 10/6/22 indicates that the wound is 3.5 x 2.8 x 0.5 cm, unstageable, and improving. Resident #1's care plan was revised on 10/13/22 to include "actual L [left] heel wound inner aspect," as a skin breakdown focus. An intervention for diabetic foot checks was added on 10/25/22.	F 686		

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A Nurse Practitioner (NP) note dated 10/19/22 reveals that "symptoms related to the injury [pressure ulcer] have worsened." The note discloses "entire heel back eschar. Dressing removed was from 10/13. Foul smell. Redness around eschar. Reported to the DON [Director of Nursing] that the daily dsg [dressing] ordered is not being followed."

Wound Nurse noted dated 10/20/22 reveals that the wound has increased in size to 5.5 x 6.1 x 0.2 cm, unstageable, and deteriorating. S/He writes that Resident #1's wound "has worsened this week d/t [due to] issue with dressing changes."

Resident #1's MAR or TAR does not reveal dressing orders or documentation that the dressing was changed from 10/7/22 through 10/19/22.

Review of Resident #1's medical record reveals that s/he does not have:
A comprehensive skin assessment on 9/14/22 readmission;
A Braden Scale risk assessment [score predicting the risk of developing pressure sores] from 3/13/22 through 1/3/23;
Physician orders for wound dressing changes or treatment from 9/14/22 through 9/28/22;
Daily documentation of wound monitoring from 9/14/22 through 9/26/22;
Weekly skin checks from 9/14/22 through 9/26/22;
Weekly wound evaluations from 9/14/22 through 9/28/22;
Change of condition documentation for a new skin impairment identified on 9/27/22;
A care plan focus reflective of actual wound from 9/14/22 through 10/12/22;

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Documentation of dressing changes from 10/7/22 through 10/19/22;
A weekly wound evaluation from 10/7/22 through 10/19/22;
Weekly skin checks from 11/25/22 through 12/13/22;
A care plan intervention for daily diabetic foot checks from 9/14/22 through 10/14/22; or
Documentation of daily diabetic foot checks from 9/14/22 through 12/13/22.

The facility was unable to produce evidence of missing skin and wound assessments/evaluations, dressing and treatment orders, dressing changes, change of condition documentation, or diabetic foot checks for Resident #1 when requested on 1/10/23 at 10:20 AM by the surveyor.

A 12/14/22 hospital orthopedic progress note reveals that Resident #1 was transferred to the emergency department on 12/13/22 and orthopedic surgery was consulted for his/her left heel ulcer. The note reveals: "On exam left heel ulcer probes to bone with thin eschar, which with removal has substantial fibrinous and necrotic tissue."

A hospital operative report from 12/20/22 states "Given the extent and location of the wound, presence of peripheral artery insufficiency, and the infectious burden related to the left heel wound, multiple providers had discussed with the patient that a left transtibial amputation would be appropriate," and Resident #1 had his/her left leg amputated below the knee on that day.

Interview:

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Per interview on 1/4/23 at 12:36 PM, the Unit Manager confirmed that there was a dressing on Resident #1's heel when s/he first discovered the wound. S/He was unable to determine how long the pressure ulcer had been present and how long the dressing had been in place for.

Per interview on 1/4/23 at 1:01 PM, the Administrator (ADM) confirmed that there had not been an initial nursing assessment, including a skin assessment for Resident #1's readmission on 9/14/22. The ADM confirmed that there was not a weekly skin check documented between 9/14/22 and the initial documentation of Resident #1's pressure ulcer by the facility.

On 1/4/23 at 2:55 PM, the Unit Manager stated that there is a glitch with putting in orders for readmissions. When a resident is out of the facility for three or more days, orders are deleted, and the nurse must start from scratch to put orders in. There is no way of knowing what the previous orders were for a readmission but standard nursing orders, like skin assessments, should be there [in the EMR]. This could be one of the reasons Resident #1 did not have skin checks or diabetic foot checks as a nursing order.

Per interview on 1/5/23 at 2:48 PM the Medical Director confirmed that nursing orders for daily foot checks for diabetic residents is a standard of care and should be a standard nursing order for all diabetics. S/He also confirmed that head to toe skin checks are to be done for all residents on return from the hospital.

Per interview on 1/6/23 at 8:21 AM, Resident #1, stated that staff could have been more preventative with his/her care. S/He had noticed

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the spot on his/her foot months before staff started treating it and had told staff about his/her concern. S/He stated that by the time the Wound Nurse saw his/her heel, it was big and orange. S/He said that sometimes the dressing wouldn't be changed for 5-6 days. A later interview with Resident #1 on 1/10/23 at 4:10 pm reiterated the above and expanded to explain that staff did not look at his/her feet every day. [Resident #1's 1/10/23 minimum data set (MDS) assessment revealed the resident had no cognitive impairment with a brief interview for mental status (BIMS) score of 15 out of 15.]

On 1/6/22 at 11:55 AM, the Director of Nursing confirmed that the facility policy titled Skin Integrity and Wound Management should be followed by nursing staff for all residents.

On 1/6/22 at 12:30 PM, the Regional Clinical Consultant stated that it is up to nursing judgment to add diabetic foot checks into nursing orders or care plans as it is not something standard the facility does for all diabetics. S/He confirmed that there is not written policy or procedure in place to ensure that a residents transfer of care information for wounds is entered into [the electronic medical record system].

On 1/9/23 at 9:20 AM, the Unit Manager stated that there is a diabetic protocol that should be implemented for every resident with diabetes. Once triggered, it will add orders for daily diabetic foot checks. S/He stated that nurses are working to the order and might not do daily diabetic foot checks if there is not an order for it. S/He stated that there is not a facility procedure on how to enter in orders and staff need something to refer to about the process.

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On 1/9/23 at 12:15 PM, a Licensed Practical Nurse (LPN) stated that s/he will do daily diabetic foot checks when they pop up on the medication administration record (MAR) or treatment administration record (TAR).

On 1/9/23 at 1:22 PM, the Director of Nursing stated that when a change of condition form is filled out for new wounds, weekly skin and wound evaluations will auto populate in the EMR. S/He confirmed that a change of condition form is not being done all the time and it might be due to a training issue.

On 1/9/23 at 3:19 PM, an LPN stated that s/he will do diabetic foot checks if they are on the TAR.

On 1/10/23 at 9:50 AM, an LPN stated that skin checks and diabetic foot checks will pop up on the TAR if they are due. When asked if the diabetic residents on his/her assignment that day needed their feet checked every day, s/he stated that s/he was unaware that they did.

On 10/10/23 at 10:20 AM, the Director of Nursing confirmed that the skin risk evaluation used by the facility was the "Braden Scale for Predicting Pressure Sore Risk Assessment."

Per interview on 1/10/23 at 11:55 AM, the Wound Nurse stated that Resident #1's wound was severe when s/he first cared for it. S/He said there have been issues around dressings not being changed at the facility and she had made management aware. Sometimes staff cannot answer question about residents' wound management, and s/he encounters situations where wound evaluations were not correct. S/He

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has done informal education sessions with staff and has offered to do a formal educational session for staff, but management has not taken him/her up on the offer.

On 1/18/23 at 9:40 AM, the Director of Nursing and the Market President confirmed that the failures to implement the skin and wound policies and procedures were due to a mix of staff not having the enough training on the policies and procedures and staff not having the competencies to implement them.

2. Resident #6

Record review and interview reveal that the facility failed to provide timely and regular skin and wound assessments placing Resident #6 at increased risk for developing pressure ulcers. This failure resulted in the discovery of three unstageable pressure ulcers and two deep tissue injuries 43 days after his/her last skin check.

Record Review

Resident #6 was admitted to the facility on 6/22/05 with diagnoses that include multiple sclerosis, muscle weakness, and dementia. Resident #3's MDS dated 11/30/22 reveals that s/he is at risk for developing pressure ulcers and needs extensive or full assistance, requiring a two person assist for bed mobility, transferring, and toileting. These clinical conditions and comorbidities are risk factors for developing pressure ulcers.

Resident #6's care plan includes the following care plan focuses:
"Resident at risk for skin breakdown related to

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impaired mobility, advanced age, poor safety awareness, frail/fragile skin, incontinence," created on 8/18/22. Interventions include: "Weekly skin check by license nurse," created on 8/18/22 and "Observe skin for signs/symptoms of skin breakdown i.e. redness, cracking, blistering, decrease sensation, and skin that does not blanche easily," created 8/18/22.
"The resident has potential for pressure ulcer development r/t [related to] decreased mobility," created on 2/15/21. Interventions include: "Follow facility protocols for the prevention/treatment of skin breakdown," created on 2/15/21 and, "Document/report to MD PRN [as needed] changes in skin status: appearance, color, wound healing, s/sx [signs and symptoms] of infection, wound size and stage," created on 2/15/21.

A physician's order dated 7/27/22 states to "Check skin condition to bilateral lower extremities daily every shift for fragile skin document in nurses note any new skin concerns".

A skin check was done on 11/9/2022. No skin injury/wound(s) were noted.

A skin check on 1/6/22 reveals the following wounds were identified:
Unstageable pressure ulcer on left buttock (lateral).
Unstageable pressure ulcer on left buttock (medial).
Unstageable pressure ulcer on right heel.
Deep tissue injury on left lateral foot.
Deep tissue injury on left medial ankle.

Review of Resident #6's medical record reveals that s/he does not have:
A Braden Scale risk assessment from 2/26/22

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through 1/11/23; or
Weekly skin checks from 11/24/22 through 1/5/23.

Interview

On 1/17/23 at 11:03 AM, the Director of Nursing confirmed there is no evidence that skin checks were done as care planned and ordered in December 2022.

3. Resident #3

Record review and interview reveal that the facility failed to provide regular skin assessments and create and implement care plan interventions for daily diabetic foot monitoring, placing Resident #3 at increased risk for developing pressure ulcers.

Record Review:

Resident #3 was admitted to the facility on 12/20/22 with diagnoses that include type 2 diabetes mellitus, hypertension, left foot drop, muscle weakness, dementia, depression, and history of stroke. Resident #3's MDS dated 12/26/22 reveals that s/he is at risk for developing pressure ulcers and totally dependent on staff, requiring a two person assist for bed mobility, transferring, and toileting. These clinical conditions and comorbidities are risk factors for developing pressure ulcers.

Resident #3's care plan includes the following care plan focus:
"Patient is at risk for skin breakdown related to Advanced age (greater than 75 years), decreased activity, impaired Cognition, incontinence, limited

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mobility, nutritional concerns and or has actual skin integrity impairments-admitted with bruises to abdomen and bilateral arms," created on 12/21/22. Interventions include: "Weekly skin check by license nurse" created on 12/21/22. The care plan does not include daily diabetic foot checks.

Review of Resident #3's medical record reveals that s/he does not have:
A Braden Scale risk assessment from 12/20/22 through 1/8/23;
A weekly skin check from 12/21/22 through 1/5/23;
A care plan intervention for daily diabetic foot checks from 12/20/22 through 1/5/23; or
Documentation of daily diabetic foot checks from 12/20/22 through 1/5/23.

The facility was unable to produce evidence of missing risk assessments, skin checks, or documentation of diabetic foot checks for Resident #3 when requested on 1/10/23 at 10:20 AM by the surveyor.

4. Resident #8

Record review and interview reveal the facility failed to provide accurate and regular skin assessments and create a care plan intervention for daily diabetic foot monitoring, placing Resident #8 increased risk for developing pressure ulcers.

Record Review:

Resident #8 was admitted to the facility on 11/27/20 with diagnoses that include type 2 diabetes mellitus, hypertension, peripheral vascular disease, chronic kidney disease, obesity,

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and coronary artery disease. Resident #8's MDS dated 11/14/22 reveals that s/he is at risk for developing pressure ulcers and needs staff assistance for transferring and toileting. These clinical conditions and comorbidities are risk factors for developing pressure ulcers.

Resident #8's care plan includes the following care plan focus:
"[Resident #8] is at risk for skin break down related to osteoarthritis, PVD [peripheral vascular disease], bilateral mastectomy. Resident currently has venous ulcers to right and left posterior legs and abrasion to left calf," created on 11/27/20. Interventions include: "skin/wounds will be checked weekly by licensed professional," created on 10/18/22. The care plan does not include daily diabetic foot checks.

Resident #8's medication administration record (MAR) reveals an order to "Cleanse BLE [bilateral lower extremities] with wound cleaner. Pat dry. Apply moisturizing cream to intact skin. For RLE [right lower extremitiy] only iodosorb cream. Apply iodine cadexomer gel to open areas and cover with foam [cover with Ag/silver foam if iodine not available]. Wrap with roller gauze (kerlix) and adhesive wrap (Coban) every evening shift, every 2 day(s) for venous ulcers." This order was documented as completed throughout October.

Skin checks from 10/1/22 and 10/11/22 indicate that Resident #8 does not have any skin injuries or wounds. This information contradicts the dressing changes for wounds documented as performed in the MAR.

Review of Resident #8's medical record reveals that s/he does not have:

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F 686	Continued From page 33 A Braden Scale risk assessment from 2/12/21 through 1/11/23; Weekly skin checks from 8/28/22 through 9/30/22; Accurate skin checks from 10/1/22 through 10/17/22; Weekly skin checks from 12/13/22 through 1/5/23; or A care plan intervention for daily diabetic foot checks from 11/27/20 through 1/5/23. Interview: On 1/18/23 at 9:15 AM, the Unit Manager stated that traveling nursing staff do not get enough education when they are hired and that some staff do not document wounds on skin checks if the wound is not new. S/He confirmed that Resident #3 had venous ulcers on both legs during October 2022 and if skin checks on 10/1/22 or 10/11/22 stated that Resident #3 did not have any wounds on 10/1/22 or 10/11/22, the skin checks would not be accurate. On 1/18/23 at 11:00 AM, the Director of Nursing confirmed that there is no evidence that skin checks were completed for the above dates per facility policy and care plan. 5. Resident #2 Record review and interview reveal that the facility failed to provide an accurate comprehensive skin assessment on readmission and implement care plan interventions for daily diabetic foot monitoring, placing Resident #2 at increased risk for developing pressure ulcers. Record Review:	F 686		

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Resident #2 was initially admitted to the facility on 7/29/22 and readmitted to the facility from the hospital on 9/1/22 with diagnoses that include type 2 diabetes mellitus, chronic respiratory failure, hypertension, chronic pain syndrome, chronic kidney disease, arthritis, anemia, congestive heart failure, legal blindness, and depression. Resident #2's care plan dated 8/9/22 reveals s/he needs staff assistance for transferring and toileting. These clinical conditions and comorbidities are risk factors for developing pressure ulcers.

A 9/1/22 transition of care note [discharge summary] from the hospital reveals on pages 5-8 that Resident #2 had multiple assessed wounds and dressings including: a right heel wound described as red, with a small open area and boggy with a foam dressing; a left heel wound described as red and boggy with a foam dressing; and a left planter foot wound, described as black, brown, and open to air.

A 9/1/22 nursing skin assessment does not document the above wounds noted in the 9/1/22 transition of care.

Resident #2's care plan includes the following care plan focuses:
"Resident is at risk of skin breakdown r/t [related to] Seborrheic Dermatitis [skin condition affecting the scalp] < DM [diabetes] and alterations in mobility," created on 8/9/22. Interventions include: "Observe skin for signs/symptoms of skin breakdown i.e. redness, cracking, blistering, decrease sensation, and skin that does not blanche easily," created on 8/9/22 and "Weekly skin check by license nurse," created 8/9/22.

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F 686	Continued From page 35 "The resident has a diagnosis of diabetes: Insulin Dependent," created on 8/3/22. Interventions include: "Diabetic foot checks daily. Observe feet/toes/ankles/soles/heels noting alteration in skin integrity, color, temperature, and cleanliness," created on 8/3/22. Review of Resident #2's medical record reveals that s/he does not have: An accurate comprehensive readmission skin evaluation on 9/1/22; A Braden Scale risk assessment [score predicting the risk of developing pressure sores] from 8/8/22 through 12/20/22; or Documentation of daily diabetic foot checks from 9/1/22 through 12/30/22. The facility was unable to produce evidence of missing risk assessments or documentation of diabetic foot checks for Resident #2 when requested on 1/10/23 at 10:20 AM by the surveyor.	F 686		
F 726 SS=K	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).	F 726	F 726 Specific Corrective Action Facility Assessment was reviewed and updated on 02/14/2023 by DON and Administrator to assure that residents are not admitted or retained if they have needs that can not be met.	03/03/23

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F 726	Continued From page 36 §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Per record review and interview, the facility failed to ensure that licensed nurses and other nursing personnel have the knowledge and competencies to provide skin and diabetic foot care for 5 of 6 sampled residents at risk for skin break down. Findings include: The facility's Facility Assessment, last updated 7/27/22, indicates that the facility is able to provide care and services related to skin integrity and management of medical conditions related to diabetes. "Part 2: Services and Care We Offer Based on our Residents' Needs a. Skin integrity: Pressure injury prevention and care, wound care (surgical, pressure, other skin wounds) b. Management of medical conditions:	F 726	F726 cont... Licenses Nurses were educated with competencies to support skills set on: • Completing assessments/evaluations • Usage of the resident care plan • Weekly Head to Toe Check • Bi-weekly Shower Schedule • Foot/Skin/Wound Care • Adherence to the Care Plan • Notification of Change • Documentation LNAs were educated with competencies to support skills set on: • Completing resident observations • Usage of the resident care plan • Skin Care Program • Weekly Head to Toe skin observation • Bi-weekly Shower Schedule • Adherence to the Care Plan • Identification/reporting resident observations	

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F 726	Continued From page 37 Assessment, early identification of problems/deterioration, management of medical and psychiatric symptoms and conditions such as heart failure, diabetes, ..." Record review and interview reveals the facility had systemic failures in ensuring staff were trained and competent in skin integrity and wound management per facility policies and professional standards of care by failing to ensure nursing staff were competent in: skin and wound assessment and skin and wound assessment documentation; wound dressing changes. These failures put 5 of the 6 sampled residents [Residents #1, #2, #3, #6, and #8] at increased risk for developing new pressure ulcer and non-pressure ulcer skin impairments, and increased risk for pressure ulcer and non-pressure ulcer skin impairments complications for 4 of the 6 samples residents [Residents #1, #2, #6, and #8]. Resident #1 had a below the knee amputation as a result of pressure ulcer complications, Resident #2 had a 5th toe amputation as a result of diabetic ulcer complications, and Resident #6 had a delayed treatment for 5 pressure ulcers creating an immediate jeopardy situation for serious injury to recur if immediate corrective action was not taken. 1. It was established that training and competencies in skin assessment and wound care were not completed for all staff. Record Review: Review of 5 licensed nursing education records	F 726	F726 cont... Licensed Nurses and LNAs education was completed by 02/28/23 by designated nurse educators on the skin integrity program and their role and responsibilities. Competencies were completed for foot and wound care by the designated nurse educators completed by 02/28/2023. Method to Assess for Others Each licensed nurse and LNHA knowable base were evaluated during the training and competencies while being completed to determine if any additional education, training, or support is indicated. Systematic Process An ad hoc QAA was performed to complete a systematic review with revisions as indicated. New LNAs will be oriented and annually educated on: Completing resident observations: Usage of the resident care plan, Skin Care Program, Weekly Head to Toe skin observation, Bi-weekly Shower Schedule, Adherence to the Care Plan and Identification/reporting resident observations. New nurses will be oriented and annually educated on:	

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F 726	Continued From page 38 reveals the following: 4 of 5 licensed nurses did not have skin assessment training. 5 of 5 licensed nurses were not assessed for skin assessment competencies. 4 of 5 licensed nurses did not have wound care training. 3 of 5 licensed nurses were not assessed wound care competencies. 5 of 5 licensed nurses did not have change of condition training. Interview: Per interview on 1/4/23 at approximately 11:00 AM, the Administer revealed that the Nurse Educator, Director of Nursing (DON), and Assistant Director of Nursing had all recently stopped working at the facility. A temporary DON, who had been working at the facility less than a week when the complaint investigation started, was going to be taking on all these roles until replacements were hired. Per interview on 1/9/23 at approximately 9:00 AM, a Licensed Practical Nurse (LPN) stated that s/he did have some competencies when hired in October, but skin assessment was not one of them. On 1/9/23 at 12:25, an LPN stated that the facility did not do skin assessment competencies with him/her. On 1/9/23 at 1:22 PM, the DON confirmed that a change of condition form is not being done all the time and it might be due to a training issue. S/He confirmed that nurse training does not include skin assessment competencies, but s/he has a	F	F726 cont.. Completing assessments/evaluations, usage of the resident care plan, weekly head to toe check process, bi-weekly shower schedule, foot/skin/wound care, adherence to the care plan, notification of change, documentation. Competencies of each topic educated on are in place to affirm knowledge base post education and training to support staff comfort and adherence. These have been completed by DON/designee by 02/28/23. Unit Managers/Designee will round daily and observe clinical care delivery to identify opportunities for support in addition to daily auditing of the EHR for evidence of noncompliance in documentation to evaluate. No less than quarterly the MDS Coordinator will review the documentation during the assessment reference date to evaluate compliance with care while performing the resident assessment instruments and process.	

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F 726	Continued From page 39 plan to do so. S/He handed this surveyor a "Skin Assessment Clinical Competency Validation" worksheet and stated that this is what should be used to evaluate skin assessment competencies with staff. Review of this competency worksheet reveal critical elements of competency include evaluating skin on all parts of the body and documenting results, including: "changes in temperature, color, moisture, turgor, and integrity in the medical record." On 1/10/23 at 9:50 AM, an LPN stated that s/he did not have any skin assessment competencies since s/he was hired. On 1/10/23 between 2:59 PM and 4:30 PM, 3 licensed nursing assistants (LNA), 3 LPNs, and 1 registered nurse (RN) could not locate the skin integrity and wound management policy when asked. When showed the policy, the above staff confirmed that they had never seen it before. 2. It was established that staff are not implementing skin risk assessment, skin checks, wound evaluations, or diabetic foot checks unless there is a UDA [user defined assessment; assessment due to complete], or a treatment order to do so. Facility policy titled NSG236 Skin Integrity and Wound Management, last reviewed 9/1/22, states: "A comprehensive initial and ongoing nursing assessment of intrinsic and extrinsic factors that influences skin health, skin/wound impairment, and the ability of a wound to heal will be performed. The plan of care for the patient will be reflective of assessment findings from the comprehensive patient assessment and wound evaluation. Staff will continually observe and	F 726	F726 cont. Quality Assurance The Director of Nursing (DON) will be responsible for ensuring that this system is in place. The DON will complete an audit of eight residents per month to evaluate staff knowledge and understanding by evaluating the quality of the care provided to the resident with focus on educated areas of care for licensed nurses and LNAs. Any concerns identified will be addressed at the time of recognition. For the residents with concerns, the DON will review the competencies of identified staff. Results of the DON audit and process will be included in the facility monthly risk management/quality improvement meeting for additional consideration as determined appropriate. **Tag F 726 POC accepted on 2/16/23 by S. Stem/P. Cota**	

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F 726	Continued From page 40 monitor patients for changes and implement revisions to the plan of care as needed." Practice Standards include: "3. Complete risk evaluation on admission, re-admission, weekly for the first month, quarterly, and with significant change in condition." "6. A licensed nurse will: 6.4 Perform and document skin inspection on all newly admitted/readmitted patients weekly thereafter and with any significant change of condition 6.5 Complete wound evaluation upon admission/readmission, new in-house acquired, weekly, and with unanticipated decline in wounds." The American Diabetes Association "Standards of Care in Diabetes-2023" reveals on page S209 the recommendation for diabetics to perform daily examination of the feet to identify early foot problems. Record Review: Record review reveals the facility failed to perform: Skin risk evaluations per facility schedule for Residents #1, #2, #3, #6, and #8; Skin inspections (skin checks) per facility schedule for Residents #1, #3, #6, and #8; Pressure injury and non-pressure injury wound evaluations per facility schedule for Residents #1, #2 and #8; Daily diabetic foot checks for Residents #1, #2, and #3. See F684 and F686 for additional information regarding residents #1, #2, #3, #6, and #8.	F 726		

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F 726	Continued From page 41 Interview: On 1/5/23 at 2:48 PM the Medical Director confirmed that nursing orders for daily foot checks for diabetic residents is a standard of care and should be a standard nursing order for all diabetic residents. On 1/9/23 at 9:20 AM, the Unit Manager stated that there is a diabetic protocol that should be implemented for every resident with diabetes. Once triggered, it will add orders for daily diabetic foot checks. S/He stated that a lot of the nurses are "working to the order" [only doing what there is an order for] and might not do daily diabetic foot checks if there is not an order on a resident's MAR. On 1/10/23 at 9:50 AM, an LPN stated that skin checks and diabetic foot checks will pop up on the TAR if they are due. When asked if the diabetic residents on his/her assignment that day need their feet checked every day, s/he stated s/he was unaware that they did. On 1/10/23 at 9:50 AM, an LPN stated that s/he will do weekly skin assessments if they come up on the TAR. S/He has never had to do a head-to-toe skin assessment because those are only done on admission, and s/he has never had to do a new admission skin assessment since s/he has started working at the facility a few months ago. S/He is not aware of daily foot checks for the two residents with diabetes on the unit. S/He stated that foot checks would pop up on the TAR if they were needed. On 1/10/23 at 3:09 PM, a RN explained that s/he will perform skin risk assessments, skin checks,	F 726		

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F 726	Continued From page 42 and wound evaluations when they pop up as an alert in the electronic medical record. On 1/10/23 at 3:25 PM, an LPN, when showed the skin integrity policy, s/he stated s/he had never seen it before. S/he revealed that s/he only knows that a resident needs skin checks or foot checks by what is due on the UDA or MAR/TAR. On 1/18/23 at 9:40 AM, the Director of Nursing and the Market President confirmed that the failures to implement the skin and wound policies and procedures were due to a mix of staff not having the enough training on the policies and procedures and staff not having the competencies to implement them. 3. It was established that not all skin assessments are accurate; some staff are not doing a full body skin assessment during skin checks and some staff are only documenting new skin injuries on skin checks. Record Review: Resident #2 was readmitted to the facility from the hospital on 9/1/22. A 9/1/22 transition of care note [discharge summary] from the hospital reveals on pages 5-8 that Resident #2 had multiple assessed wounds and dressings including: a right heel wound described as red, with a small open area and boggy with a foam dressing; a left heel wound described as red and boggy with a foam dressing; and a left planter foot wound, described as black, brown, and open to air. A 9/1/22 readmission nursing skin assessment by the facility does not document the above wounds noted in the 9/1/22 transition of care.	F 726		

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F 726	Continued From page 43	F 726		

Resident #8 was admitted to the facility on 11/27/20. Skin checks and wound care notes indicate that Resident #8 had chronic venous ulcers to right and left posterior legs since admission. Resident #8 has physician's orders for treatment and dressing changes of these wounds. Skin checks from 10/1/22 and 10/11/22 reveals that Resident #8 does not have any skin injuries or wounds which contradicts the information in progress notes, the medication administration record (MAR), and treatment administration record (TAR).

Interview:

On 1/9/22 at 10:48 AM, Resident #4 stated that s/he does not recall having full body skin assessments regularly. "It might have happened a couple times. They look at my skin but not head to toe. I feel like I'd remember staff looking at my skin head-to-toe."

On 1/9/23 at 1:22 PM, the DON confirmed that skin checks are a head-to-toe assessment of all parts of the resident's body.

On 1/9/23 at 4:03 PM, the Regional Clinical Consultant stated that there is an expectation for staff to document any irregularities of the skin, not just wounds, whether they are new or not. S/He confirmed that skin checks are a full body assessment of a resident's skin.

On 1/10/23 at 9:50 AM, an LPN stated that s/he will do weekly skin assessments if they come up on the TAR. S/He has never had to do a head-to-toe skin assessment because those are only done on admission, and s/he has never had

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F 726	Continued From page 44 to do a new admission skin assessment since s/he has started working at the facility a few months ago. S/He is not aware of daily foot checks for the two residents with diabetes on the unit. S/He stated that foot checks would pop up on the TAR if they were needed. Per interview on 1/10/23 at 10:55 AM, the Wound Nurse stated s/he had made management aware that there have been issues with dressing changes for residents. S/He has encountered situations where the facility's assessment of a wound is not consistent with her/his own. S/He has offered to do formal educational sessions with facility staff, but the facility has never taken up the offer. On 1/18/23 at 9:15 AM, the Unit Manager stated that traveling nursing staff do not get enough education when they are hired and that some staff do not document wounds on skin checks if the wound is not new.	F 726		
F 835 SS=H	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility was not administered in a manner that enables it to maintain the physical well-being of each resident, whereby actions and decisions by the facility's leadership team directly contributed to	F 835		

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F 835	Continued From page 45 deficient practices at F684 and F686. Findings include: Findings of deficient practices at F684 and F686 establish that 5 of 6 sampled residents were not provided effective care to promote optimal skin health, prevent pressure injuries and non-pressure injury skin impairments, and promote healing. As a result, these 5 residents were put at increased risk for developing pressure ulcer and non-pressure ulcer skin impairments. Failure to provide care per facility policy and professional standards of practice contributed to Resident #1 receiving a below the knee amputation due to a pressure ulcer complication, Resident #2 receiving a left toe amputation due to a diabetic ulcer complication, and Resident #6 having five unidentified pressure injuries. Per interview on 1/4/23 at 3:15 PM, the Administrator stated that leadership was aware of issues related to skin assessment not being completed. S/he stated that skin assessments were addressed during the 11/11/22 QAPI (quality assurance & performance improvement) meeting. Per interview on 1/10/23 at 11:55 AM, the Wound Nurse stated that there have been issues around dressings not being changed at the facility and she had made management aware. Sometimes staff cannot answer question about residents' wound management, and s/he encounters situations where wound evaluations were not correct. S/He has done informal education sessions with staff and has offered to do a formal educational session for staff, but management has not taken him/her up on the offer.	F 835	F 835 Specific Corrective Action An Adhoc QAA committee meeting was held with the Administrator, DON, Medical Director, Market (regional) Team Members and outside consultant to review the State Agency findings. This has continued weekly with completion of a root cause analysis. Focused education and training with competencies has been completed. Education and training with competency was completed to the DON by the market (regional) team to support her ability to participate with facility staff training. A full time designated RN who has been an effective DON has been assigned five days a week to support the DON. Market and Administrative Consultant support are also assigned to support the Administrator. Method to Assess for Others In addition to the 100% head to toe skin evaluation of each resident,	03/03/23

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F 835	Continued From page 46 On 1/10/23 at 12:20 PM, the Administrator and Market President confirmed that they were aware of the issues with skin care and have been working on it since the QAPI meeting in November. When asked what the facility has done to ensure residents were receiving the appropriate skin care since the November QAPI meeting, the Administrator said that they completed facility wide skin checks, updated care plans, and have done staff education starting 1/6/23. When asked if these actions were planned or if they were initiated because of the complaint investigations, the Administrator responded that the process took time. On 1/19/23 the Market President of Special Projects confirmed in an email that the facility was "not able to find significant evidence of improvement activities related to the QAPI plan in place for skin care."	F 835	F835 cont. review of related systems (skin, pressure injury, education and competency) has been completed. Systematic Process An ad hoc QAA was performed with a root cause analysis to complete a systematic review with revisions as indicated. To support the DON a market resource nurse has been designated to work at the facility five days a week side by side to support the DONs ability to complete and manage. Two Unit Manager positions were filled 02/10/2022. A wound skin lead will be engaged at the center to support the A consulting team has been deployed to the facility to support completion, adherence and compliance along with market (regional) staff. New LNAs will be oriented and annually educated on: Completing resident observations: Usage of the resident care plan, Skin Care Program, Weekly Head to Toe skin observation, Bi-weekly Shower Schedule, Adherence to the Care Plan	
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include:			

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F 838	Continued From page 47 §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing	F 835	and Identification/reporting resident observations. New nurses will be oriented and annually educated on: Completing assessments/evaluations, usage of the resident care plan, weekly head to toe check process, bi-weekly shower schedule, foot/skin/wound care, adherence to the care plan, notification of change, documentation. Competencies of each topic educated on are in place to affirm knowledge base post education and training to support staff comfort and adherence. These have been completed by the DON/designee by 02/28/23. Unit Managers/Designee will round daily and observe clinical care delivery to identify opportunities for support in addition to daily auditing of the EHR for evidence of noncompliance in documentation to evaluate. No less than quarterly the MDS Coordinator will review the documentation during the assessment reference date to evaluate compliance with care while performing the resident assessment instruments and process.	

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F 838	Continued From page 48 patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to address in their facility assessment what staff trainings and competencies are necessary to provide the level and types of care needed for the population identified in the facility assessment. Findings include: Review of the facility's Facility Assessment Tool, last updated 7/27/22 states: Part 3: Facility Resources Needed to Provide Competent Support and Care for our Residents indicated the following under staff training/education and competencies: "3.4 Describe the staff training/education and competencies that are necessary to provide the level and types of support and care needed for your resident population. Include staff certification requirements as applicable. Potential data sources include hiring, education, competency instruction, and testing policies." The response refers to: "Attachment: Education/In-services/Mandatories." The attachment titled 2022 Mandatory Annual Education Quarterly Crosswalk, lists mandatory training topics by quarter and suggests resources for training. Footnotes indicate "Centers must determine the amount and types of additional training necessary based on a facility		F835 cont... Quality Assurance The Administrator is responsible for ensuring that all systems that have been identified as in need of revision, reinstatement, and or newly implemented have been completed and that they are effectively in place. In addition to the Administrator, the market (regional) team will be on site weekly to participate in evaluation and confirmation of compliance with ongoing consultant evaluation for a period of 2 years. Both resident and family council meetings will also review to affirm any questions, problems or concerns with care and services. The DON reports post evaluation of 10 residents per month will also be included in this review process to determine status of systems and outcomes. The facility education program status will be reviewed monthly. This will be completed with each area of education and training added to the monthly risk management/quality improvement meeting. Tag F 835 POC accepted on 2/16/23 by S. Stem/P. Cota	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 838	Continued From page 49 assessment." The attachment does not include an evaluation of the facility's training program or policies and procedures required to provide the care. On 1/18/23 at 11:50 AM, the Market President confirmed that the attachment did not include or address an evaluation of the facility's training program to ensure any training needs are met for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers, consistent with their expected roles, or an evaluation of what policies and procedures may be required in the provision of care and that these meet current professional standards of practice.	F 838	A facility wide assessment was completed on 02/14/2023 All residents have the potential to be affected. The facility conducts and documents a facility wide assessment that determines the resources necessary to care for its residents competently during both day to day operations and during emergencies. Administrative staff will be re-educated to this process. A weekly audit of the facility assessment will be completed to validat the need for review and updating related to a change that would require modification of any part of the assessment. Results of this audit will be brought to the Monthly QAPI Committee for further review and recommendations.	03/03/23
F 843 SS=C	Transfer Agreement CFR(s): 483.70(j)(1)(2) §483.70(j) Transfer agreement. §483.70(j)(1) In accordance with section 1861(l) of the Act, the facility (other than a nursing facility which is located in a State on an Indian reservation) must have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably assures that- (i) Residents will be transferred from the facility to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician or, in an emergency situation, by another practitioner in accordance with facility policy and consistent with state law; and (ii) Medical and other information needed for care and treatment of residents and, when the transferring facility deems it appropriate, for determining whether such residents can receive	F 843	**Tag F 838 POC accepted on 2/16/23 by S. Stem/P. Cota** The facility has in effect a current transfer agreement with University of Vermont Medical Center with updated signatures noted on 01/17/23. An audit was completed to validate that the facility has written transfer agreements with at least one local hospital. The facility completes a written transfer agreement with one or more hospitals, who are approved for participation under the Medicare and Medicaid programs. The NHA and DON have been re-educated to this process. The NHNDesignee will complete monthly audits of written transfer agreements to validate these agreements are current and in effect. The results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.	03/03/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475014	A. BUILDING _____ B. WING _____	C 01/19/2023

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F 843	Continued From page 50 appropriate services or receive services in a less restrictive setting than either the facility or the hospital, or reintegrated into the community will be exchanged between the providers, including but not limited to the information required under §483.15(c)(2)(iii). §483.70(j)(2) The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs. Findings include: Per review of facility documentation as part of the extended survey on 1/18/23, there is no written transfer agreement with any hospital. This was confirmed by the facility Executive Director on 1/18/23 at 11:41 AM.	F 843	**Tag F 843 POC accepted on 2/16/23 by S. Stem/P. Cota**	

F 843	Continued From page 50 appropriate services or receive services in a less restrictive setting than either the facility or the hospital, or reintegrated into the community will be exchanged between the providers, including but not limited to the information required under §483. 15(c)(2)(iii). §483.70(j)(2) The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs. Findings include: Per review of facility documentation as part of the extended survey on 1/18/23, there is no written transfer agreement with any hospital. This was confirmed by the facility Executive Director on 1/18/23 at 11:41 AM.	F 843		